**Patient Name:**

**DOB:**

**MRN:**

**Clinic Location:**

**Patient Questionnaire**

**Dear Patient:**

**Please complete this questionnaire before you come for your appointment. Be sure to call us as soon as possible if you cannot make your appointment. *Thank you.***

**Your Name**

**Day Phone # Evening Phone #**

**Address**

**City State Zip**

**Date of Birth Age**

**Primary Physicians’s Name, Address, and Phone**

**Referring Physician’s Name, Address, and Phone**

**Preferred Pharmacy Phone #**

***QUESTIONS ABOUT YOUR CURRENT PROBLEM:***

**1. When did your pain problem first occur?**

**2. How did it happen? Accident at work Accident at home Following surgery**

 **Please check (!) one: Car accident Other accident**

**3. Have you ever had this pain before? If yes, explain.**

**4. Place an X on each line between 0 and 10 to indicate your level of pain last week:**

**\_\_\_\_\_\_\_\_\_\_\_Worst this week**

**\_\_\_\_\_\_\_\_\_\_\_(no pain) 0 10 (worst possible pain)**

**\_\_\_\_\_\_\_\_\_\_\_Best this week**

\_\_\_\_\_\_\_\_\_\_(no pain) 0 10 (worst possible pain)

\_\_\_\_\_\_\_\_\_\_Average this week

\_\_\_\_\_\_\_\_\_\_(no pain) 0 10 (worst possible pain)

5. What makes your pain worse?

6. What makes your pain better?

7. Yes No Do you think your pain is caused by something that is different or more serious than what your doctor has told you?

8. What do you think is the cause of your pain?